



CUSTOMER FOCUSED HEALTH CARE DELIVERY AND SATISFACTION November 2003

Acad Med. 2003 Sep;78(9):945-9.

Examination room presentations in general internal medicine clinic: patients' and students' perceptions.

Rogers HD, Carline JD, Paauw DS.

University of Washington School of Medicine, 1024 E. Shelby Street, Seattle, WA 98102, USA. hdr@u.washington.edu

PURPOSE: To determine if patients are more satisfied with their health care when medical students present in the exam room to both the attending physician and patient than they are when medical students present outside the exam room to only the attending. To determine medical students' preference for location of presentation and the reasons for their preference. To determine if exam-room presentations promote the education of medical students to a greater degree than presentations outside of the exam room. **METHOD:** In 2001, 108 patients and 142 fourth-year medical students at internal medicine (IM) clinics affiliated with the University of Washington School of Medicine were asked to complete an 11-point ordinal scale questionnaire on their attitudes toward medical student presentations. **RESULTS:** One hundred patients (93%) and 68 medical students (48%)

responded. Patients with in-room presentations enjoyed working with the medical student more than did patients with out-of-room presentations. Both groups expressed a preference for in-room presentations on future visits and a high level of comfort with student and physician discussing their health. Medical students reported a slight preference for presenting out of the room. When presenting in the room, students reported learning more about physical diagnosis and bedside manner and less about mechanism of disease than when presenting out-of-room. **CONCLUSIONS:** Patients preferred in-room case presentations and were

comfortable with medical students and physicians discussing their health in their presence. In-room presentations also foster instruction on bedside manner and physical diagnosis. These data suggest that both patients and students would benefit from participating in more in-room presentations.

PMID: 14507630 [PubMed - indexed for MEDLINE]

AIDS Care. 2003 Aug;15(4):451-62.

Dissatisfaction with medical care among women with HIV: dimensions and

**Library Program Office
Office of Information
Veterans Health Administration**

associated factors.

Burke JK, Cook JA, Cohen MH, Wilson T, Anastos K, Young M, Palacio H, Richardson J, Gange S.

Mental Health Services Research Program, Department of Psychiatry, University of Illinois at Chicago, 104 South Michigan Avenue, Suite 900, Chicago, IL 60603, USA. jburke@psych.uic.edu

Studies have shown that women with HIV/AIDS in the USA are less likely than men to have access to appropriate health care and to utilize services, including the latest antiretroviral drug therapies. One explanation for this underutilization is patient dissatisfaction with medical care. Dissatisfaction with care has been shown to be associated not only with treatment underutilization, but also with discontinuity of care and poor clinical outcomes. Using Patient Satisfaction Questionnaire data from a national cohort of women with HIV, this study examines levels of dissatisfaction across seven established dimensions of care, and uses multivariate analysis to identify patient characteristics associated with these dimensions (N = 1,303). Women were most dissatisfied with access to care and the technical quality of care, and least dissatisfied with financial aspects of care and their providers' interpersonal manner. Women who reported poor health, who had depressive symptomatology, who were not receiving antiretroviral therapy (ART), who had no consistent care providers or who were Hispanic/Latina were more likely to be dissatisfied across most dimensions of care. Implications for enhancing clinical care for women with HIV/AIDS and overcoming barriers to utilization of care and treatment are discussed.

PMID: 14509860 [PubMed - indexed for MEDLINE]

AIDS Care. 2003 Aug;15(4):475-81.

Effects of empowerment among HIV-positive women on the patient-provider relationship.

Marelich WD, Murphy DA.

Department of Psychology, California State University, Fullerton, PO Box 6846, Fullerton, CA 92834, USA. wmarelich@fullerton.edu

An assessment of the effects of HIV/AIDS patients' empowered behaviours on the patient-provider relationship was undertaken. Participants were 50 HIV-positive women ranging in age from 23 to 48 years, with 60% of the sample African American, 24% Latina, 6% White and 10% mixed/other race. Descriptive and canonical correlation analyses were used to investigate the interrelationships between patients' empowered behaviours and self-reported interactions with their providers. Positive associations were noted between patients' medical decision-making involvement and patient-provider interactions. Patients reporting greater decision-making involvement, had higher levels of communication with their providers, and received more information and positive affect from their providers. Health care providers of HIV-positive women are encouraged to cultivate empowered behaviours in their patients.

PMID: 14509862 [PubMed - indexed for MEDLINE]

Am J Med Sci. 2003 Sep;326(3):136-40.

Building the case for cultural competence.

Genao I, Bussey-Jones J, Brady D, Branch WT Jr, Corbie-Smith G.

Division of General Medicine, Emory University School of Medicine, Atlanta, GA 30003, USA. igenao@emory.edu

Cultural competence in the provision of health care is a very important area of investigation and is receiving recognition at multiple levels. Minority groups

constitute a significant and growing percentage of our population. However, there has been no commensurate increase in the number of minority physicians. There is a tremendous need for medical professional schools and health care organizations to implement formal cultural competence training for current and future health professionals. In this article, we present the findings of an extensive literature review that describes how several factors have brought the need for cultural competence to the forefront. These factors include a greater appreciation for the impact of culture on health, changes in U.S. demographics, increased awareness in health care disparities, and modifications in legislative and accreditation mandates.
PMID: 14501229 [PubMed - indexed for MEDLINE]

Arch Phys Med Rehabil. 2003 Sep;84(9):1343-9.

Satisfaction with medical rehabilitation in patients with orthopedic impairment. Mancuso M, Smith P, Illig S, Granger CV, Gonzales VA, Linn RT, Ottenbacher KJ. Division of Rehabilitation Sciences, University of Texas medical Branch, Galveston, TX 77555-1028, USA.
OBJECTIVE: To examine patient satisfaction after orthopedic impairment at 80 to 180 days after inpatient rehabilitation. DESIGN: Retrospective design examining records from facilities subscribing to the Uniform Data System for Medical Rehabilitation (UDSmr). SETTING: Information submitted to UDSmr from 1997 to 1998 by 177 hospital and rehabilitation facilities from 40 states. PARTICIPANTS: The sample (N=7781) was 72.63% female and 88.60% non-Hispanic white, with a mean age +/- standard deviation of 73.07+/-11.81 years, and average length of stay (LOS) of 13.84+/-10.48 days. INTERVENTION: Usual rehabilitation care. Main outcome measures Level of satisfaction 80 to 180 days after discharge as well as motor, cognitive, and subscale ratings for the FIM trade mark instrument. Predictor variables included gender, age, English language, marital status, discharge setting, LOS, rehospitalization, FIM gain, and primary payer. RESULTS: A logistic regression model was used to predict patient satisfaction at follow-up. Five statistically significant (P<.05) variables were found and correctly classified 94.9% of the patients. Discharge motor FIM rating, rehospitalization, age, patient's primary language, and discharge setting were associated with increased satisfaction. Discharge motor FIM ratings were significantly associated with increased satisfaction in patients with joint replacements and lower-extremity fractures. CONCLUSION: Functional and demographic variables were identified as predictors of satisfaction in patients with orthopedic impairments.
PMID: 13680572 [PubMed - indexed for MEDLINE]

BMJ. 2003 Oct 11;327(7419):861.

What information do patients need about medicines? Ask the patients--they may want to know more than you think.
Dickinson D, Raynor DK.
Consumation, 53 Hosack Road, London SW17 7QW.
david.dickinson@consumation.com
PMID: 14551106 [PubMed - indexed for MEDLINE]

BMJ. 2003 Oct 11;327(7419):862-3.

What information do patients need about medicines? "Doc, tell me what I need to know"--a doctor's perspective.

Kennedy JG.

Cedar Brook Practice, 11 Kingshill Close, Middlesex UB4 8DD.

jim@the-coreresource.com

PMID: 14551108 [PubMed - indexed for MEDLINE]

BMJ. 2003 Oct 11;327(7419):863-4.

What information do patients need about medicines? Perspectives from the pharmaceutical industry.

Bonaccorso S, Sturchio JL.

Merck & Co, One Merck Drive, Whitehouse Station, NJ 08889-0100, USA.

silvia_bonaccorso@merck.com

PMID: 14551109 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):703-9.

Effects of communicating individual risks in screening programmes: Cochrane systematic review.

Edwards A, Unigwe S, Elwyn G, Hood K.

Department of Primary Care, University of Wales Swansea Clinical School, Singleton Park, Swansea SA2 8PP. a.g.k.edwards@swan.ac.uk

OBJECTIVE: To assess the effects of different types of individualised risk communication for patients who are deciding whether to participate in screening. DESIGN: Systematic review. DATA SOURCES: Specialist register of the Cochrane consumers and communication review group, scientific databases, and a manual follow up of references. SELECTION OF STUDIES: Studies were randomised controlled trials addressing decisions by patients whether or not to undergo screening and incorporating an intervention with an element of "individualised" risk communication-based on the individual's own risk factors for a condition (such as age or family history). OUTCOME MEASURES: The principal outcome was uptake of screening tests; further cognitive and affective measures were also assessed to gauge informed decision making. RESULTS: 13 studies were included, 10 of which addressed mammography programmes. Individualised risk communication

was associated with an increased uptake of screening tests (odds ratio 1.5, 95% confidence interval 1.11 to 2.03). Few cognitive or affective outcomes were reported consistently, so it was not possible to conclude whether this increase in the uptake of tests was related to informed decision making by patients.

CONCLUSIONS: Individualised risk estimates may be effective for purposes of population health, but their effects on increasing uptake of screening programmes may not be interpretable as evidence of informed decision making by patients. Greater attention is required to ways of developing interventions for screening programmes that can achieve this.

Publication Types:

Review

Review, Academic

PMID: 14512475 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):745-8.

Strategies to help patients understand risks.

Paling J.

Risk Communication Institute, 5822 NW 91 Boulevard, Gainesville, FL 32653, USA.

drp@trci.info

PMID: 14512489 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):741-4.

Simple tools for understanding risks: from innumeracy to insight.

Gigerenzer G, Edwards A.

Centre for Adaptive Behaviour and Cognition, Max Planck Institute for Human Development, Lentzeallee 94, 14195 Berlin, Germany.

gigerenzer@mpibberlin.mpg.de

PMID: 14512488 [PubMed - indexed for MEDLINE]

BMJ. 2003 Sep 27;327(7417):736-40.

Risk communication in practice: the contribution of decision aids.

O'Connor AM, Legare F, Stacey D.

Ottawa Health Research Institute, Ottawa Hospital, Civic Campus, C4-1053 Carling Ave, Ottawa, ON, Canada K1Y 4E9. aoconnor@ohri.ca

PMID: 14512487 [PubMed - indexed for MEDLINE]

Br J Nurs. 2003 Sep 11-24;12(16):966-71.

The role of the critical care nurse in the delivery of bad news.

Peel N.

Acute Neurosurgical Ward, Royal Hallamshire Hospital, Sheffield.

The NHS Plan and the Code of Professional Conduct direct the nurse to include the family in decisions made about the care of the patient. Well-developed communication is an essential interpersonal skill and a professional means of establishing nurse-patient/family trust. The use of a reliable and valid assessment tool based on Leske's Inventory will enable the nurse to prioritize the needs of each family at a stressful time and in unfamiliar surroundings, whether it is the intimidating critical care setting or not. Key training of critical care nurses in the sensitive area of delivering bad news is lacking. Failure to assess effectively individualized family needs and to plan, implement and evaluate the care given to relatives precludes holistic care. When care is managed to include the family, empowerment of the patient and family will lead to autonomy.

PMID: 14508420 [PubMed - indexed for MEDLINE]

Camb Q Healthc Ethics. 2001 Fall;10(4):451-2; discussion 452-5.

"Help me die".

Campbell CS, Kimsma G.

PMID: 14533413 [PubMed - indexed for MEDLINE]

Can Oper Room Nurs J. 2001 Jun;19(2):21-5.

Dealing with difficult people.

Keenan-Hayes S.

Inpatient Psychiatric Unit, Queensway-Carlton Hospital, Ottawa.

PMID: 14509027 [PubMed - indexed for MEDLINE]

Care Manag J. 2003 Spring;4(1):46-52.

Intercultural collaboration: an approach to long-term care for urban American Indians.

Hendrix LR.

Department of Physiological Nursing, School of Nursing, University of California, San Francisco, USA. levanneh@mindspring.com

Most long term care of older urban American Indians is provided in the community by family, extended family, or fictive kin, and American Indians are rarely found in long term care facilities. An approach to American Indian elderly requires some understanding of Indian ways in order to be effective therapeutically and acceptable to the older Indian. Multiple interviews, a focus group, and a survey conducted in an urban Indian community revealed the consistent perception by American Indian elderly and their families that health care providers lacked information, understanding, and respect for Indian culture.

PMID: 14502878 [PubMed - indexed for MEDLINE]

Care Manag J. 2003 Spring;4(1):37-45.

The ethnogeriatric imperative.

Yeo G.

Stanford Geriatric Education Center, Stanford University School of Medicine VAPAHCS, Building 4 (182B-SGEC), Palo Alto, CA 94304, USA.

gwenyeo@standord.edu

PMID: 14502877 [PubMed - indexed for MEDLINE]

Caring. 2003 Aug;22(8):38-9.

How to deal with difficult and manipulative clients.

Leichtling B.

PMID: 14582486 [PubMed - indexed for MEDLINE]

Compend Contin Educ Dent. 2003 Jul;24(7):492-4.

Exceeding patient expectations.

Levin RP.

Dentures provide an excellent opportunity for patient expectation management. While the dentists and staff should always be caring and supportive, they also should be honest and clear about the potential results. Benefits and deficits of any treatment option must be communicated.

PMID: 14508928 [PubMed - indexed for MEDLINE]

Fla Nurse. 2001 Mar;49(1):27.

Nearly half of all women 65 and older use herbal products to feel better, but don't tell their doctors.

Yoon SJ.

PMID: 14508971 [PubMed - indexed for MEDLINE]

Hastings Cent Rep. 2001 Sep-Oct;31(5):29-39.

Walking a fine line. Physician inquiries into patients' religious and spiritual beliefs.

Cohen CB, Wheeler SE, Scott DA; Anglican Working Group in Bioethics.

Kennedy Institute of Ethics, Georgetown University, Washington, D.C., USA.

PMID: 12974116 [PubMed - indexed for MEDLINE]

Health Care Food Nutr Focus. 2002 Jun;18(10):10-1.

Improving customer service. You are up to bat!

Dahl M.

PMID: 12974106 [PubMed - indexed for MEDLINE]

Health Care Food Nutr Focus. 2002 May;18(9):1, 3-5.

Four rules to guide customer service.

Johnson JE.

Georgetown University Hospital, Washington, D.C., USA.

PMID: 12974101 [PubMed - indexed for MEDLINE]

Health Prog. 2003 Sep-Oct;84(5):12-23.

Prejudice and the medical profession. Racism, sometimes overt, sometimes subtle, continues to plague U.S. health care.

Clark PA.

St. Joseph's University, Mercy Health System, Philadelphia, USA.

Publication Types:

Historical Article

PMID: 14513752 [PubMed - indexed for MEDLINE]

Health Serv J. 2003 Sep 4;113(5871):24-5.

Violence against staff. Government health warning.

Cole A.

Violence against NHS staff is increasing despite four years of zero tolerance.

Staff working in community settings can be particularly vulnerable. Many trusts lack robust and consistent reporting mechanisms. NHS anti-fraud service is overhauling reporting system.

PMID: 14513606 [PubMed - indexed for MEDLINE]

Health Soc Care Community. 2003 Sep;11(5):405-14.

A review and commentary of the social factors which influence stroke care:

issues of inequality in qualitative literature.

Mold F, McKevitt C, Wolfe C.

Department of Public Health Sciences, Kings' College London, London, UK.

freda.mold@kcl.ac.uk

Stroke is the third most common cause of death in the UK and a major cause of adult disability. Stroke services have long been criticised for being deficient and there is evidence that some aspects of care provision vary across different population groups. While there is information about the patterns of service provision, questions remain about processes which might underlie these variations. The present paper sought to assess how well the processes which might lead to inequity in the delivery and uptake of stroke services are currently understood by reviewing the qualitative literature in the area. The review was carried out by systematically searching online literature databases, using keyword and bibliographical searches, within a particular time frame. In total, 55 articles were reviewed, including studies related to primary and secondary clinical care, as well as social care. Articles focused on both professionals' and patients' perspectives. The review reports the cultural factors and processes which have been identified as possible causes of barriers to professionals' delivering stroke services, as well as issues which influence patients' uptake of services. Issues identified in the literature were categorised into four broad thematic areas: conceptualisations of stroke illness and ageing, socio-economic factors, resource allocation and information provision. These themes are then revisited through the hypothesis that the concept of social and personal identity could cast new light on our understanding of how inequity in stroke care provision might arise. It is argued that the ways in which professionals and patients view themselves and each other influences their interaction, and in turn, the delivery and demand for services. Finally, the authors suggest areas where further research is warranted.

Publication Types:

Review

Review, Academic

PMID: 14498837 [PubMed - indexed for MEDLINE]

Healthc Exec. 2003 Sep-Oct;18(5):60-1.

Mentoring Diversity. Serving a diverse patient population calls for diverse leadership.

Ambrose L.

PMID: 14503079 [PubMed - indexed for MEDLINE]

Healthc Exec. 2003 Sep-Oct;18(5):68-9.

Happy employees, happier patients. Excellence in patient service is linked to the work environment.

Gross JW.

St. Elizabeth Medical Center, Edgewood, KY, USA.

PMID: 14503083 [PubMed - indexed for MEDLINE]

Healthc Financ Manage. 2003 Sep;57(9):46-8.

On the road to consumer-driven health care.

Gustafson BM.

Gustafson & Associates, Inc., Port Washington, Wis., USA.

solutions@gustassoc.com

Under a consumer-driven health plan (CDHP), patients assume responsibility for designing their own healthcare coverage package. PFS professionals need to be prepared to respond to the new needs and concerns of patients who become consumers of health care. Such consumers will require greater access to information on service cost and pricing as they "shop" for providers. CDHP members also will expect PFS professionals to be able to provide them with appropriate information on the health plan's adjudication and payment of claims. PMID: 14503143 [PubMed - indexed for MEDLINE]

Healthc Financ Manage. 2003 Sep;57(9):90-6.

When putting patients first fits the bill.

Cohen D, Hoffman P.

Cedars-Sinai Medical Center, Los Angeles, USA. Donell.Cohen@cshs.org

Cedars-Sinai Medical Center in Los Angeles revamped its billing system to better meet patients' needs for comprehensible billing information. After changing its billing format and processes, the provider's phone-call volume decreased 31 percent, translating into an annual savings of more than \$250,000. Patient feedback regarding the new system has been over-whelmingly positive. The new billing system has contributed to 20 percent acceleration in payment.

PMID: 14503150 [PubMed - indexed for MEDLINE]

Hosp Case Manag. 2003 Oct;11(10):159-60.

Make diversity a part of daily operations.

[No authors listed]

PMID: 13677700 [PubMed - indexed for MEDLINE]

Hosp Case Manag. 2003 Oct;11(10):152-4.

Patient satisfaction depends on staff morale.

[No authors listed]

PMID: 13677697 [PubMed - indexed for MEDLINE]

Hosp Health Netw. 2003 Sep;77(9):10, 12.

Patients' opinions matter.

Kennedy TD 3rd.

Publication Types:

Letter

PMID: 14560743 [PubMed - indexed for MEDLINE]

IRB. 2003 May-Jun;25(3):9-11.

The subject advocate: protecting the interests of participants with fluctuating decisionmaking capacity.

Stroup S, Appelbaum P.

University of North Carolina School of Medicine, USA.
PMID: 14569988 [PubMed - indexed for MEDLINE]

IRB. 2003 May-Jun;25(3):12-9.

Informing study participants of research results: an ethical imperative.
Fernandez CV, Kodish E, Weijer C.
Division of Pediatric Hematology/Oncology, Department of Pediatrics, IWK Health
Centre and Dalhousie University, Halifax, Nova Scotia, Canada.
PMID: 14569989 [PubMed - indexed for MEDLINE]

IRB. 2002 Jul-Aug;24(4):6-8.

Pilot study: does the white coat influence research participation?
Merz JF, Rebbeck TR, Sankar P, Meagher EA.
Department of Medical Ethics, University of Pennsylvania School of Medicine,
USA.
PMID: 13678029 [PubMed - indexed for MEDLINE]

Issue brief (Grantmakers Health). 2001 Feb 28;(9):1-28.

Advancing quality through patient safety.
Grantmakers In Health, Washington, D.C., USA.
PMID: 14535287 [PubMed - indexed for MEDLINE]

Issue Brief (Inst Health Care Costs Solut). 2003 Sep-Oct;2(5):1-16.

Reshaping consumer behavior: decision support at the point-of-care.
Goff V.
Business Health Network, Falls Church, VA, USA.
PMID: 14518464 [PubMed - indexed for MEDLINE]

Issue Brief (Public Policy Inst (Am Assoc Retired Pers)). 2003
Oct;(IB64):1-16.

Consumer-directed personal care services for older people in the U.S.
Coleman B.
PMID: 14575049 [PubMed - indexed for MEDLINE]

J Am Acad Dermatol. 2003 Oct;49(4):709-11.

Patients' attitudes toward medical student participation in a dermatology
clinic.
Townsend B, Marks JG, Mauger DT, Miller JJ.
Department of Psychiatry, Dermatology and Health Evaluation Sciences, Penn State
College of Medicine, Hershey, Pennsylvania 17033, USA.
To study the attitudes of patients toward medical student participation in a
dermatology clinic, we surveyed 208 volunteer adult outpatients at a university
setting. Almost all patients (98.5%) had no preference regarding medical student

participation in their care or prefer medical student participation in their care. The majority of patients (84.5%) felt comfortable disclosing personal information to the medical student. Most patients (94.2%) enjoyed the interaction with the medical student, 22% of patients wanted time alone with the physician, and 91.8% of patients agreed that the students understood their health care needs. The majority of patients in this study enjoyed their interactions with the students and felt comfortable disclosing information. Some patients want to spend time alone with the physician. Permission for medical student participation should be requested.

PMID: 14512921 [PubMed - indexed for MEDLINE]

J Am Acad Nurse Pract. 2003 Aug;15(8):341-9.

Promoting lifestyle change in the prevention and management of type 2 diabetes. Whittemore R, Bak PS, Melkus GD, Grey M.

Yale University School of Nursing, New Haven, Connecticut, USA.
robin.whittemore@yale.edu

PURPOSE: To present the theoretical background for lifestyle change interventions in the prevention and management of type 2 diabetes and to provide pragmatic strategies for advanced practice nurses (APNs) to incorporate such interventions into their practices. **DATA SOURCES:** Selected scientific literature and the Internet. **CONCLUSIONS:** There is an epidemic of obesity and type 2 diabetes among adults in the United States. Preventing or managing these health conditions requires significant lifestyle changes by individuals. **IMPLICATIONS FOR PRACTICE:** APNs are in a key role to deliver lifestyle change interventions, particularly in the primary care setting. Strategies to assist APNs with lifestyle change counseling include (a) assessment, (b) mutual decision making, (c) referral to education programs, (d) individualized treatment goals, (e) strategies to assist with problem solving, (f) continuing support and encouragement, (g) relapse prevention, and (h) ongoing follow-up.

Publication Types:

Review

Review, Tutorial

PMID: 14509099 [PubMed - indexed for MEDLINE]

J Am Diet Assoc. 2003 Oct;103(10):1347-9.

Exploring patient satisfaction with foodservice through focus groups and meal rounds.

Watters CA, Sorensen J, Fiala A, Wismer W.

Regional Nutrition & Food Service, Capital Health, Alberta, Canada.
cwatters@cha.ab.ca

The purpose of this study was to investigate adult patients' perceptions of hospital foodservice through focus groups with patients postdischarge and with nurses. The focus group themes included an emphasis on health, quality, freshness, and appropriateness; variety, selection, and choice; inability to provide feedback; menu errors; accessibility to food on the units; service; tray layout; and waste. The themes emerging from the focus groups were further explored through meal round interviews with patients (n=116) to determine areas for improvement. Patients thought food served in the hospital should be a model for a healthy diet. Ongoing education and communication with patients and nurses

is important in improving satisfaction with foodservice.

PMID: 14520255 [PubMed - indexed for MEDLINE]

J Am Diet Assoc. 2003 Oct;103(10):1282-4.

Customer service in health care--dietetics professionals can take the lead.

McClusky KW.

PMID: 14520244 [PubMed - indexed for MEDLINE]

J Cardiovasc Nurs. 2003 Sep-Oct;18(4):267-73.

The use of non face-to-face communication to enhance preventive strategies.

Hughes S.

Akron General Medical Center, Akron, Ohio 44333, USA. shughes@agmc.org

Multiple studies have demonstrated disappointingly low rates of persistence with therapies recommended to reduce cardiovascular risk. Non face-to-face communication has been employed as a strategy to increase the rate of adherence with both pharmacologic and lifestyle modification risk-reduction measures. In addition to the impact on adherence, these interventions have the potential to affect intermediate measures, such as increased access to care, increased patient satisfaction, and decreased resource utilization. Improvement in clinical outcomes is the ultimate measure of success of this intervention.

Publication Types:

Review

Review, Tutorial

PMID: 14518602 [PubMed - indexed for MEDLINE]

J Cardiovasc Nurs. 2003 Sep-Oct;18(4):319-25.

The effect of lifestyle interventions on quality of life and patient satisfaction with health and health care.

Berra K.

Stanford Center for Research in Disease Prevention, Stanford University School of Medicine, Palo Alto, Calif 94304, USA. kberra@stanford.edu

Improvements in quality of life (QOL) and high levels of patient satisfaction are associated with cardiovascular risk reduction (CRR) programs. Understanding the influences that lifestyle change and medical management have on individuals, their families, and their environment can help target successful interventions that benefit both QOL and patient satisfaction. It is well known that multiple aspects of one's QOL can be affected by the development of coronary artery disease. Development of depressive symptoms and anxiety, along with declines in functional capacity and family and social functioning, has been reported. QOL is a dynamic continuum, relating to many aspects of one's life. Social relationships, financial situations, work-related issues, physical limitations, and intellectual challenges all play a role in determining QOL and satisfaction within the health care setting. Self-perception of how these factors negatively or positively influence one's QOL also exerts a strong influence. This article will review the influence of primary and secondary prevention programs on QOL and patient satisfaction.

Publication Types:

Review

Review, Tutorial

PMID: 14518607 [PubMed - indexed for MEDLINE]

J Clin Oncol. 2003 Oct 15;21(20):3777-84.

Patients' perceptions of quality of life after treatment for early prostate cancer.

Clark JA, Inui TS, Silliman RA, Bokhour BG, Krasnow SH, Robinson RA, Spaulding M, Talcott JA.

Department of Health Services, Boston University School of Public Health, Boston, MA 02118, USA. jaclark@bu.edu

PURPOSE: Treatment for early prostate cancer produces problematic physical side effects, but prior studies have found little influence on patients' perceived health status. We examined psychosocial outcomes of treatment for early prostate cancer. **PATIENTS AND METHODS:** Patients with previously treated prostate cancer and a reference group of men with a normal prostate-specific antigen (PSA) level and no history of prostate cancer completed questionnaires. Innovative scales assessed behavioral consequences of urinary dysfunction, sexuality, health worry, PSA concern, perceived cancer control, treatment decision making, decision regret, and cancer-related outlook. Urinary, bowel, and sexual dysfunction were assessed with symptom indexes; health status was assessed by the Physical and Mental Summaries of the Short Form (SF-12) Health Survey.

RESULTS: Compared with men without prostate cancer, prostate cancer patients reported greater urinary, bowel, and sexual dysfunction, but similar health status. They reported worse problems of urinary control, sexual intimacy and confidence, and masculinity, and greater PSA concern. Perceptions of cancer control and treatment decisions were positive, but varied by treatment: prostatectomy patients indicated the highest and observation patients indicated the lowest cancer control. Bowel and sexual dysfunction were associated with poorer sexual intimacy, masculinity, and perceived cancer control; masculinity and PSA concern were associated with greater confidence in treatment choice; and diminished sexual intimacy and less interest in PSA were associated with greater regret. **CONCLUSION:** The lack of change in global measures of health status after treatment for early prostate cancer obscures important influences in men's lives; cancer diagnosis and treatment complications may result in complex outcomes. Aggressive treatment may confer confidence in cancer control, yet be countered by diminished intimate relationships and masculinity, which accompany sexual dysfunction.

PMID: 14551296 [PubMed - indexed for MEDLINE]

J Clin Oncol. 2003 Oct 1;21(19):3659-64.

Quality of life in women with breast cancer during the first year after random assignment to adjuvant treatment with marrow-supported high-dose chemotherapy with cyclophosphamide, thiotepa, and carboplatin or tailored therapy with Fluorouracil, epirubicin, and cyclophosphamide: Scandinavian Breast Group Study 9401.

Brandberg Y, Michelson H, Nilsson B, Bolund C, Erikstein B, Hietanen P, Kaasa S, Nilsson J, Wiklund T, Wilking N, Bergh J; Scandinavian Breast Group Study 9401. Department of Oncology, Karolinska Hospital, S-171 76 Stockholm, Sweden.

PURPOSE: To compare, in high-risk breast cancer patients, the effects on health-related quality of life (HRQoL) of two adjuvant treatments. Treatments were compared at eight points during the first year after random assignment to treatment with tailored fluorouracil, epirubicin, and cyclophosphamide (FEC) therapy for nine courses versus induction FEC therapy for three courses followed

by high-dose chemotherapy with cyclophosphamide, thiotepa, and carboplatin (CTCb) supported by peripheral-blood stem cells. PATIENTS AND METHODS: From March 1994 to March 1998, 525 breast cancer patients (estimated relapse risk > 70% within 5 years with standard therapy) were included in the Scandinavian Breast Group 9401 study. HRQoL evaluation, using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ)-C30 and EORTC Breast Cancer Module-23, included 408 of 446 eligible patients in Finland, Norway, and Sweden. RESULTS: Eighty-four percent to 95% of the patients completed questionnaires at eight points of assessment. Nostatistically significant overall differences were found between the tailored FEC group and the CTCb group for any of the HRQoL variables. Statistically significant differences over time were found for all HRQoL variables. HRQoL in the CTCb group demonstrated a steeper decrease, but a faster recovery than in the tailored FEC group. Emotional functioning improved with increased time from randomization. Higher levels of problems in body image and arm symptoms were reported in the tailored FEC group compared with the CTCb group. Sexual functioning and satisfaction were impaired during the study period. CONCLUSION: Both treatments had a negative influence on HRQoL during the treatment period. Despite the aggressive therapies, the patient's HRQoL returned to levels found at inclusion on most variables.

Publication Types:

Clinical Trial

Multicenter Study

Randomized Controlled Trial

PMID: 14512398 [PubMed - indexed for MEDLINE]

J Gerontol Nurs. 2003 Sep;29(9):32-41; quiz 55-6.

Nursing needs of hospitalized older adults. Consumer and nurse perceptions.

Chang E, Chenoweth L, Hancock K.

University of Western Sydney, School of Nursing, Family and Community Health, Building ER, Parramatta Campus, Locked Bag 1797, Penrith South DC NSW 1797, Australia.

The proportion of older adults is increasing in Australia, and the proportion of older adults requiring medical care is expected to increase in the future. At the same time, budget restrictions are a reality for Australia's health system. Increasing need and decreasing resources suggest the need to focus on the quality aspect of treatment and care for older adults. Little research has been conducted in the area of perceived nursing needs of elderly patients during hospitalization. This is an important area of research because it is increasingly recognized that elderly patients have specialized needs and are the major consumers of health care. Even less research has compared patient and carer perceptions with those of nursing staff. This article is a literature review and an investigation of the quality of care elderly patients receive, and of patient and nurse perceptions of the importance of various nursing activities. Quality of care is reviewed in terms of perceptions of nursing care priorities and elderly patients' satisfaction with the quality of nursing care they receive. Research examining nurses' perceptions related to why they are unable to consistently provide quality nursing care to all elderly patients is also reviewed. By identifying the nursing needs of elderly patients and educating nursing staff about these needs, professional practice can be guided and improvements in quality of care, patient satisfaction, and patient outcomes may occur.

Publication Types:

Review
Review, Tutorial
PMID: 14528747 [PubMed - indexed for MEDLINE]

J Holist Nurs. 2003 Sep;21(3):228-41.

Restoring the patient's voice. The therapeutics of illness narratives.
Sakalys JA.
University of Colorado Health Sciences Center, School of Nursing, USA.
Reflective and insightful autobiographical accounts of illness not only illuminate fundamental disruptions in selfhood and continuity of life that accompany illness, but authors of such accounts also maintain that narration is an important way to make sense of an illness episode, to restore personhood and connectedness, and to reclaim the illness experience from the medical meta-narrative. That witnessing and helping to order illness narratives can be a caring/healing nursing practice modality with significant healing potential is supported both by narrative theory and by nursing's theoretical and philosophical legacy. The challenge for the nurse guided by narrative ideas is to give primacy to the patient's voice, to listen for meaning rather than for facts, and to provide a relationship enabling the evolution of the patient's story.

Publication Types:
Review
Review, Tutorial
PMID: 14528848 [PubMed - indexed for MEDLINE]

J Holist Nurs. 2003 Sep;21(3):301-17.

Caring presence. Delineation of a concept for holistic nursing.
Covington H.
Basin Clinic-Naturita, Colorado, USA.
Interest in presence within a caring relationship has gained renewed attention in the past decade. For five decades, presence has been implicit and explicit in nursing theory. Recognizing caring presence as important to nursing, the 13th Annual Caring Research Conference in 1992 spotlighted the topic. Yet few publications appeared in nursing literature between the years 1980 to 1991. Since that time, interest in and literature about the topic has greatly increased. The elusive nature of the phenomenon, however, makes it difficult to define. This article presents a review of literature of presence and suggests a working definition that could be used as the basis for research. Placing presence within the context of caring provides a way for the holistic nurse to offer caring-healing ways of being and relating.

Publication Types:
Review
Review, Tutorial
PMID: 14528852 [PubMed - indexed for MEDLINE]

J Med Internet Res. 2003 Jul-Sep;5(3):e17.

The impact of health information on the Internet on health care and the physician-patient relationship: national U.S. survey among 1,050 U.S. physicians.

Murray E, Lo B, Pollack L, Donelan K, Catania J, Lee K, Zapert K, Turner R.
Royal Free and University College School of Medicine at University College
London, Department of Primary Care and Population Sciences, London, UK.
elizabeth.murray@pcps.ucl.ac.uk

BACKGROUND: Public use of the Internet for health information is increasing but its effect on health care is unclear. We studied physicians' experience of patients looking for health information on the Internet and their perceptions of the impact of this information on the physician-patient relationship, health care, and workload. **METHODS:** Cross-sectional survey of a nationally-representative sample of United States physicians (1050 respondents; response rate 53%). **RESULTS:** Eighty-five percent of respondents had experienced a patient bringing Internet information to a visit. The quality of information was important: accurate, relevant information benefited, while inaccurate or irrelevant information harmed health care, health outcomes, and the physician-patient relationship. However, the physician's feeling that the patient was challenging his or her authority was the most consistent predictor of a perceived deterioration in the physician-patient relationship (OR = 14.9; 95% CI, 5.5-40.5), in the quality of health care (OR = 3.4; 95% CI, 1.1-10.9), or health outcomes (OR = 5.6; 95% CI, 1.7-18.7). Thirty-eight percent of physicians believed that the patient bringing in information made the visit less time efficient, particularly if the patient wanted something inappropriate (OR = 2.5; 95% CI, 1.5-4.4), or the physician felt challenged (OR = 3.6; 95% CI, 1.8-7.2). **CONCLUSIONS:** The quality of information on the Internet is paramount: accurate relevant information is beneficial, while inaccurate information is harmful. Physicians appear to acquiesce to clinically-inappropriate requests generated by information from the Internet, either for fear of damaging the physician-patient relationship or because of the negative effect on time efficiency of not doing so. A minority of physicians feels challenged by patients bringing health information to the visit; reasons for this require further research.

PMID: 14517108 [PubMed - indexed for MEDLINE]

J Nurs Adm. 2003 Sep;33(9):478-85.

The relationship between nurse staffing and patient outcomes.

Sasichay-Akkadechanunt T, Scalzi CC, Jawad AF.

Faculty of Nursing, Chiang Mai University, Thailand. thitinut@chiangmai.ac.th

OBJECTIVES: To examine the association between in-hospital mortality and four nurse staffing variables-the ratio of total nursing staff to patients, the proportion of RNs to total nursing staff, the mean years of RN experience, and the percentage of nurses with bachelor of science in nursing degrees.

BACKGROUND: Studies suggest that nurse staffing changes affect patient and organizational outcomes, but the impact of nurse staffing on patient outcomes has not been studied sufficiently and the results of the previous studies are equivocal. Additionally, the studies of the relationship between nurse staffing and patient outcomes or the impact of nurse staffing on patient outcomes had not been previously examined in Thailand. **METHODS:** A retrospective, cross-sectional, observational research design was employed to study the research questions. Data of 2531 patients admitted to seven medical units and 10 surgical units of a 2300-bed university hospital in Thailand was used. All data of patients admitted to this hospital with four common groups of principal diagnoses (diseases of the heart, malignant neoplasms [cancer of all forms], hypertension and cerebrovascular diseases, and pneumonia and other diseases of the lung) was extracted from patient charts and discharge summaries in the calendar year 1999.

Nurse staffing variables for each nursing unit in 1999 came from nursing service department databases. Multivariate logistic regression was used to determine the relationship between nurse staffing variables and in-hospital mortality.

RESULTS: The findings of this study revealed that the ratio of total nurse staffing to patients was significantly related to in-hospital mortality in both partial and marginal analyses, controlling for patient characteristics. In addition, the ratio of total nursing staff to patients was found to be the best predictor of in-hospital mortality among the four nurse staffing variables, controlling for patient characteristics. The study did not find any significant relationship between in-hospital mortality and three nurse staffing variables (the proportion of RNs to total nursing staff, the mean years of RN experience, and the percentage of bachelor degree prepared nurses) probably due to the low variation of these variables across nursing units or because they may have correlated with other variables. **CONCLUSIONS:** The findings of this study add to our understanding of the importance of nurse staffing and its relationship to the patient outcome of hospital mortality. Further, the findings also provide information for hospital and nursing administrators to use when restructuring the clinical workforce, revising hospital policies, or making contractual decisions on behalf of nursing and public beneficiaries.

PMID: 14501564 [PubMed - indexed for MEDLINE]

J Nurs Adm. 2003 Sep;33(9):434-6.

Nurse caring behaviors and patient satisfaction: improvement after a multifaceted staff intervention.

Yeakel S, Maljanian R, Bohannon RW, Coulombe KH.

General Surgery Unit, Hartford Hospital, CT 06102, USA.

Publication Types:

Evaluation Studies

PMID: 14501558 [PubMed - indexed for MEDLINE]

J Palliat Med. 2003 Jun;6(3):409-15.

Comment in:

J Palliat Med. 2003 Jun;6(3):429-31.

Responding to requests regarding prayer and religious ceremonies by patients near the end of life and their families.

Lo B, Kates LW, Ruston D, Arnold RM, Cohen CB, Puchalski CM, Pantilat SZ, Rabow MW, Schreiber RS, Tulskey JA.

Program in Medical Ethics, Division of General Internal Medicine, University of California, San Francisco, USA. bernie@medicine.ucsf.edu

Prayer and religious ceremonies may help patients near the end of life and their relatives find comfort and discover meaning in their lives. In this paper, we analyze how physicians might respond in two situations regarding prayer and religious ceremonies. First, how should physicians respond when such patients or their families ask physicians to pray for them or with them? Physicians' responses to such requests will depend on their own religious and spiritual beliefs, the congruence of their beliefs with those of the patient and family, and their relationship with the patient. Many physicians may be willing to be present and stand silently while the patient prays. Second, how should physicians respond when such patients and families seek to carry out their religious and spiritual practices in the hospital? Religious ceremonies can provide meaning, hope, and solace to patients and families. Institutional

guidelines regarding religious ceremonies should allow as much leeway as is compatible with good care both for the patient for whom the ritual is offered and also for other patients within the facility. Physicians should inquire whether there are religious and spiritual practices that patients and families would like to engage in. However, physicians should be cautious about recommending specific ceremonies or practices. Physicians can respond to requests and respect patients' spiritual needs in ways that may deepen the therapeutic doctor-patient relationship, without compromising their own religious and spiritual beliefs or professional roles.
PMID: 14509486 [PubMed - indexed for MEDLINE]

J Palliat Med. 2003 Jun;6(3):381-90.

Oregon physicians' perceptions of patients who request assisted suicide and their families.

Ganzini L, Dobscha SK, Heintz RT, Press N.

Department of Veterans Affairs, Oregon Health and Science University, Portland, Oregon 97239, USA. ganzinil@ohsu.edu

In 1997, the Oregon Death with Dignity Act was enacted, allowing a physician to prescribe a lethal dose of medication for a competent, terminally ill patient who requests one. In 2000, we conducted single, semistructured, in-depth, face-to-face interviews with 35 Oregon physicians who received a request for a lethal prescription. The interviews focused on physicians' perceptions of patients who requested assisted suicide, the reasons for the request, and the reactions of their families. The interviews were audiotaped, transcribed, and analyzed using qualitative techniques. Physicians described requesting patients as having strong and vivid personalities characterized by determination and inflexibility. These individuals wanted to control the timing and manner of death and to avoid dependence on others. These preferences reflected long-standing coping and personality traits. Physicians perceived that these patients viewed living as purposeless and too effortful, and that they were ready for death. The requests, which were forceful and persistent, could occur at any point after diagnosis of the terminal illness, and were paralleled by refusal of medical interventions including palliative treatments. Many family members were reluctant to support these requests until they recognized the strength of the preference.

PMID: 14509483 [PubMed - indexed for MEDLINE]

J Palliat Med. 2003 Jun;6(3):489-99.

The comprehensive care team: a description of a controlled trial of care at the beginning of the end of life.

Rabow MW, Petersen J, Schanche K, Dibble SL, McPhee SJ.

Division of General Medicine, University of California, San Francisco, San Francisco, California, USA. mrabow@medicine.ucsf.edu

OBJECTIVE: To describe the characteristics, acceptability, and basic efficacy of an outpatient palliative care consultation service for patients with serious illness continuing to receive treatment for their underlying disease. DESIGN: Structured interviews of intervention patients enrolled in a prospective, nonrandomized, controlled trial. SETTING: General medicine practice in an urban, academic medical center. PATIENTS: Ninety outpatients with cancer, advanced congestive heart failure, or advanced chronic obstructive pulmonary disease. INTERVENTIONS: Palliative care consultation to primary care physicians (PCPs);

educational and supportive services to patients and their families. OUTCOME MEASURES: Physician referrals, program assessment by patients, observations of clinical consultation team members. RESULTS: A majority of PCPs (61%) referred patients to the project, which provided an extensive panel of services despite significant financial constraints. Patients reported improved satisfaction with their family (85.7%), PCP (80%), and the medical center at large (65.7%) as a result of these services. Patients found discussing advance care planning difficult (66%), but desired these conversations (66%). Team members observed significant palliative care needs among this population of outpatients, however, PCPs did not implement a significant number of the consultation team's recommendations. CONCLUSIONS: Outpatient palliative care consultation and services for patients continuing to pursue treatment of their underlying disease are acceptable and helpful to patients. However, barriers to implementation of palliative care treatments in this population must be explored.

Publication Types:

Clinical Trial

Controlled Clinical Trial

PMID: 14509498 [PubMed - indexed for MEDLINE]

J Vasc Surg. 2003 Oct;38(4):866-7.

What to tell patients harmed by other physicians.

Jones JW, McCullough LB, Richman BW.

Department of Surgery (M580), University of Missouri, One Hospital Drive, Columbia, MO 65212, USA. jonesjw@health.missouri.edu

PMID: 14560248 [PubMed - indexed for MEDLINE]

JAMA. 2003 Oct 8;290(14):1899-905.

Safety of patients isolated for infection control.

Stelfox HT, Bates DW, Redelmeier DA.

Department of Medicine, University of Toronto, Toronto, Ontario.

stelfox@fas.harvard.edu

CONTEXT: Hospital infection control policies that use patient isolation prevent nosocomial transmission of infectious diseases, but may inadvertently lead to patient neglect and errors. OBJECTIVE: To examine the quality of medical care received by patients isolated for infection control. DESIGN, SETTING, AND PATIENTS: We identified consecutive adults who were isolated for methicillin-resistant *Staphylococcus aureus* colonization or infection at 2 large North American teaching hospitals: a general cohort (patients admitted with all diagnoses between January 1, 1999, and January 1, 2000; n = 78); and a disease-specific cohort (patients admitted with a diagnosis of congestive heart failure between January 1, 1999, and July 1, 2002; n = 72). Two matched controls were selected for each isolated patient (n = 156 general cohort controls and n = 144 disease-specific cohort controls). MAIN OUTCOME MEASURES: Quality-of-care measures encompassing processes, outcomes, and satisfaction. Adjustments for study cohort and patient demographic, hospital, and clinical characteristics were conducted using multivariable regression. RESULTS: Isolated and control patients generally had similar baseline characteristics; however, isolated patients were twice as likely as control patients to experience adverse events during their hospitalization (31 vs 15 adverse events per 1000 days; P<.001). This difference in adverse events reflected preventable events (20 vs 3 adverse events per 1000 days; P<.001) as opposed to nonpreventable events (11 vs 12

adverse events per 1000 days; $P = .98$). Isolated patients were also more likely to formally complain to the hospital about their care than control patients (8% vs 1%; $P < .001$), to have their vital signs not recorded as ordered (51% vs 31%; $P < .001$), and more likely to have days with no physician progress note (26% vs 13%; $P < .001$). No differences in hospital mortality were observed for the 2 groups (17% vs 10%; $P = .16$). CONCLUSION: Compared with controls, patients isolated for infection control precautions experience more preventable adverse events, express greater dissatisfaction with their treatment, and have less documented care.

PMID: 14532319 [PubMed - indexed for MEDLINE]

JONAS Healthc Law Ethics Regul. 2003 Sep;5(3):60-4.

Legal consequences of the moral duty to report errors.

Hall JK.

Texas Tech University School of Medicine, Amarillo, 79124-5710, USA.

werner@ama.ttuhsu.edu

Increasingly, clinicians are under a moral duty to report errors to the patients who are injured by such errors. The sources of this duty are identified, and its probable impact on malpractice litigation and criminal law is discussed. The potential consequences of enforcing this new moral duty as a minimum in law are noted. One predicted consequence is that the trend will be accelerated toward government payment of compensation for errors. The effect of truth-telling on individuals is discussed.

PMID: 12972948 [PubMed - indexed for MEDLINE]

JONAS Healthc Law Ethics Regul. 2003 Sep;5(3):68-72.

Improving patient satisfaction through the consistent use of scripting by the nursing staff.

Mustard LW.

Healthcare Negligence Control, Chapel Hill, NC 27515, USA.

executivehealthcare@yahoo.com

An exploratory developmental model proposes a new method for responding to patient satisfaction on the basis of the hospital nurse obtaining subjective patient information at the patient's bedside during the first 24 hours of hospital admission and the day before discharge. The personal interview by the nurse uses a guided script, the Voice of the Patient (Figure 1), which is the front sheet in the medical record and a part of the critical medical care documents common to all hospital medical records. The information recorded in the Voice of the Patient actually comprises one-sentence quotes from the patient used by the hospital caregivers in responding to patient satisfaction during hospitalization, when care flaws can be corrected.

PMID: 12972950 [PubMed - indexed for MEDLINE]

Jt Comm J Qual Saf. 2003 Oct;29(10):551-5.

Unanticipated harm to patients: deciding when to disclose outcomes.

Barron WM, Kuczewski MG.

Center for Clinical Effectiveness, Loyola University Health System, Maywood, Illinois, USA.

BACKGROUND: Patient safety standards of the Joint Commission on Accreditation of

Healthcare Organizations require that "patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes." WHAT OUTCOMES SHOULD TRIGGER DISCLOSURE: Given that all medical treatments have an array of possible outcomes, how do we confidently say that an outcome is unanticipated? It is proposed that an adverse outcome meet one of two criteria to be considered unanticipated: (1) It would not be included in a reasonable informed consent process for treatment of the patient's condition(s) and/or would not be expected during the usual course of treatment; and (2) it may have been caused by human or systemic error--that is, it is not immediately possible to clearly and decisively rule out error. This definition requires less judgment because it represents an extension of the existing norms of communication that are expressed through the process of informed consent. The norms of the informed consent process require that the patient be given all pertinent information needed to participate in future treatment decision making. CONCLUSIONS AND RECOMMENDATIONS FOR ORGANIZATIONAL POLICIES: Institutional policies and procedures should provide a clear approach to the identification, reporting, and discussion of unanticipated adverse outcomes, whether or not they are associated with error, as well as guidance and an educational program to help physicians, staff, and students disclose unanticipated adverse events and error in the most appropriate manner. PMID: 14567264 [PubMed - indexed for MEDLINE]

Jt Comm J Qual Saf. 2003 Jun;29(6):309-15.

What is the best way to schedule patient follow-up appointments?

Saine PJ, Baker SM.

Dartmouth Medical School, Hanover, New Hampshire, USA.

patrick.j.saine@hitchcock.org

BACKGROUND: What is the best way to schedule follow-up appointments? The most popular model requires the patient to negotiate a follow-up appointment time on leaving the office. This process accounts for the majority of follow-up patient scheduling. There are circumstances when this immediate appointment arrangement is not possible, however. The two common processes used to contact patients for follow-up appointments after they have left the office are the postcard reminder method and the prescheduled appointment method. METHODS: In 2001 the two methods

used to contact patients for follow-up appointments after they had left the clinic were used for all 2,116 reappointment patients at an ophthalmology practice at Dartmouth-Hitchcock Medical Center. The number of completed successful appointments, the no-show rate, and patient satisfaction for each method were calculated. RESULTS: A larger number of patient reappointments were completed using the prescheduled appointment procedure than the postcard reminder system (74% vs 54%). The difference between completed and pending appointments (minus no-shows) of the two methods equaled 163 patients per quarter, or 652 patients per year. Additional revenues associated with use of the prescheduled appointment letter method were estimated at \$594,600 for 3 years. SUMMARY: Using the prescheduled appointment method with a patient notification letter is advised when patients do not schedule their appointments on the way out of the office.

PMID: 14564749 [PubMed - indexed for MEDLINE]

Manag Care. 2003 Sep;12(9 Suppl):3-5.

Consumer-driven health care: transforming medical management.
Herzlinger RE.
Harvard Business School, Boston, USA.
PMID: 14535128 [PubMed - indexed for MEDLINE]

Manag Care. 2003 Sep;12(9):18-25.

Consumer-directed health care: too good to be true?
Cross M.
PMID: 14528669 [PubMed - indexed for MEDLINE]

Manag Care. 2003 Sep;12(9):29-32.

Pharmacy benefit starts to reflect push for consumer-directed care.
Berberabe T.
PMID: 14528670 [PubMed - indexed for MEDLINE]

Med Care. 2003 Sep;41(9):1096-109.

Nurse staffing models as predictors of patient outcomes.
McGillis Hall L, Doran D, Baker GR, Pink GH, Sidani S, O'Brien-Pallas L, Donner GJ.
Nursing Effectiveness, Utilization, and Outcomes Research Unit, Faculty of Nursing, University of Toronto, Toronto, Ontario, Canada.
l.mcgillishall@utoronto.ca
BACKGROUND: Little research has been conducted that examined the intended effects of nursing care on clinical outcomes. OBJECTIVE: The objective of this study was to evaluate the impact of different nurse staffing models on the patient outcomes of functional status, pain control, and patient satisfaction with nursing care. RESEARCH DESIGN: A repeated-measures study was conducted in all 19 teaching hospitals in Ontario, Canada. SUBJECTS: The sample comprised hospitals and adult medical-surgical and obstetric inpatients within those hospitals. MEASURES: The patient's functional health outcomes were assessed with the Functional Independence Measure (FIM) and the Medical Outcome Study SF-36. Pain was assessed with the Brief Pain Inventory and patient perceptions of nursing care were measured with the nursing care quality subscale of the Patient Judgment of Hospital Quality Questionnaire. RESULTS: The proportion of regulated nursing staff on the unit was associated with better FIM scores and better social function scores at hospital discharge. In addition, a mix of staff that included RNs and unregulated workers was associated with better pain outcomes at discharge than a mix that involved RNs/RPNs and unregulated workers. Finally, patients were more satisfied with their obstetric nursing care on units where there was a higher proportion of regulated staff. CONCLUSIONS: The results of this study suggest that a higher proportion of RNs/RPNs on inpatient units in Ontario teaching hospitals is associated with better clinical outcomes at the time of hospital discharge.
PMID: 12972849 [PubMed - indexed for MEDLINE]

Med Care. 2003 Sep;41(9):1058-64.

Trust and satisfaction with physicians, insurers, and the medical profession.

Balkrishnan R, Dugan E, Camacho FT, Hall MA.

Department of Management and Policy Sciences, University of Texas, School of Public Health, Houston, Texas 77225, USA. rbalkris@wfubmc.edu

BACKGROUND: Conceptual or theoretical analysts of trust in medical settings distinguish among markedly different objects or types of trust. However, little is known about how similar or different these types of trust are in reality and the relationship of trust with satisfaction. **OBJECTIVES:** This exploratory study conducted a comparison among trust in one's personal physician, health insurer, and in the medical profession, and examined whether the relationship between trust and satisfaction differs according to the type of trust in question.

RESEARCH DESIGN: Random national telephone survey using validated multi-item measures of trust and satisfaction. **SUBJECTS:** A total of 1117 individuals aged

20 years and older with health insurance and reporting 2 healthcare professional visits in the past 2 years. **RESULTS:** Rank-order correlation analyses find that

both physician and insurer trust are sensitive to the amount of contact the patient has had and their adequacy of choice in selecting the physician or insurer. Trust in the medical profession stands out as being uniquely related to

patients' desire to seek care and their preference for how much control physicians should have in making medical decisions. Adding satisfaction to the

models reduced the number of significant predictors of insurance trust disproportionately. **CONCLUSIONS:** Consistent with theory, we found both

substantial similarities and notable differences in the sets of factors that predict 3 different types of trust. Trust and satisfaction are much less

distinct with respect to health insurers than with respect to physicians or the medical profession.

PMID: 12972845 [PubMed - indexed for MEDLINE]

Med Care Res Rev. 2003 Sep;60(3):347-65.

A paradigm shift in patient satisfaction assessment.

Otani K, Harris LE, Tierney WM.

Indiana University-Purdue University, Fort Wayne, USA.

The authors investigated the relationships between patients' reactions to health care attributes and their overall satisfaction with primary care. The study

found the following: (1) patients' overall satisfaction levels are

disproportionately influenced by low levels of their reactions (less satisfied)

to the primary care attribute, rather than simply averaged out among attribute reactions. This is a noncompensatory relationship. (2) The marginal impact of

primary care attributes on overall satisfaction decreases at higher levels of patients' reactions (more satisfied) to primary care attributes, indicating a

nonlinear relationship. Patients combine their reactions to the health care attributes by means of noncompensatory and nonlinear models to form their

overall satisfaction. Decision makers should selectively concentrate training resources on those areas of attributes showing high dissatisfaction rather than

attempt to improve an attribute that showed the largest parameter estimate. This approach would not only save resources but result in better outcomes of patient satisfaction.

PMID: 12971233 [PubMed - indexed for MEDLINE]

Mil Med. 2003 Sep;168(9):744-9.

Patient satisfaction in military medicine: status and an empirical test of a model.

Mangelsdorff AD, Finstuen K.

U.S. Army-Baylor University Graduate Program in Health Care Administration, U.S. Army Medical Department Center and School (MCCS-HFB) 3151 Scott Road, Fort Sam

Houston, TX 78234-6135, USA.

The Department of Defense (DoD) is concerned about how well military medical treatment facilities in the military health system perform. Patient expectations, attitudes, and health care use have been examined in numerous studies; the results are fairly consistent. Eligible beneficiaries report moderate satisfaction with the health care received. In 1994-2001, annual DoD and monthly ambulatory patient surveys were conducted in military medical treatment facilities. The DoD surveys document how patients perceive the care provided. The obvious research concerns are: requirements for conducting surveys; who should be surveyed: eligible beneficiaries or actual users; when; where; representative sample; how often to conduct assessment; data collection methods; analytic schemes; overall trends; predictors of satisfaction; use of results; and timeliness of findings. This study examines these issues and analyzes raw data from selected annual DoD and monthly ambulatory surveys. The overall level of perceived satisfaction has been "good" over the years surveys were used. The model demonstrated the use of examining demographic and attitudinal components of patient satisfaction in military medical facilities.

PMID: 14529251 [PubMed - indexed for MEDLINE]

Nurs Adm Q. 2003 Jul-Sep;27(3):254-6.

The patient's point of view--IT matters.

Simpson RL.

Nursing Informatics, Cerner Corporation, Kansas City, Missouri, USA.

PMID: 13677191 [PubMed - indexed for MEDLINE]

Nurs Adm Q. 2003 Jul-Sep;27(3):197-202.

Love and caring. Ethics of face and hand--an invitation to return to the heart and soul of nursing and our deep humanity.

Watson J.

University of Colorado Health Sciences Center, 4200 E. 9th Avenue, Box C-288, Denver, CO 80262, USA. Jean.Watson@uchsc.edu

This manuscript offers a new view of old and timeless values: the essential ethic of love, informed by contemporary European philosophies, and caring theory, as well as ancient poetry and wisdom traditions. It integrates some of the philosophical views of Levinas and Logstrup with Watson's Transpersonal Caring Theory. The metaphysics, metaphors, and meanings associated with "ethics of face," the "infinity of the human soul," and "holding another's life in our hands" are tied to a deeply ethical foundation for the timeless practice of love and caring, as a means to sustain, not only our shared humanity, but the profession of nursing itself.

Publication Types:

Review

Review, Tutorial

PMID: 13677183 [PubMed - indexed for MEDLINE]

Nurs Adm Q. 2003 Jul-Sep;27(3):203-7.

Why not person-centered care? The challenges of implementation.
Hagenow NR.

Genesys Health System, One Genesys Parkway, Grand Blanc, Michigan 48439, USA.

Do we always "keep our eye on the ball"--the patient? Do we continue to put our hearts and souls, as leaders, into building and supporting that relationship between persons serving and persons served? This article illuminates both the challenges and benefits of implementing a sustainable person centered care model. Patient-centered care (PCC) models have been around for many years, and in fact, many hear "PCC" and cringe. Nurses in particular view such models as economic tools for productivity. It is then hypocrisy to be carrying a name such as PCC. And yet, despite the history and the barriers, it is the only model for a better way of providing health care in America. The author shares her models on how to begin this work of transformation and create a new culture that always "points to true north"--the persons served and the persons serving.

PMID: 13677184 [PubMed - indexed for MEDLINE]

Nurs Econ. 2003 Jul-Aug;21(4):158-66.

Identifying nurse staffing and patient outcome relationships: a guide for change in care delivery.

Potter P, Barr N, McSweeney M, Sledge J.

Barnes-Jewish Hospital, St. Louis, MO, USA.

PMID: 14509874 [PubMed - indexed for MEDLINE]

Nurs Ethics. 2003 Sep;10(5):462-71.

Undertaking the role of patient advocate: a longitudinal study of nursing students.

Altun I, Ersoy N.

Kocaeli University, Turkey. insafaltun@mynet.com

Patient advocacy has been claimed as a new role for professional nurses and many codes of ethics for nurses state that they act as patient advocates. Nursing education is faced with the challenge of preparing nurses for this role. In this article we describe the results of a study that considered the tendencies of a cohort of nursing students at the Kocaeli University School of Nursing to act as advocates and to respect patients' rights, and how their capacities to do so changed (or not) as a result of their nursing education. This longitudinal study used a questionnaire consisting of 10 statements relating to patient care. It was performed both at the start (1998) and at the end (2002) of the nursing training. At the beginning of their course 77 students participated; in the study. After four years, only 55 students participated, the reason for this drop in number being unknown. The questions asked nurses if patients should have: the right to receive health care; the right to participate in the decision-making process about their treatment; the right always to be told the truth; and the right to have access to their own medical records. They were also asked: if quality of life should be a criterion for discontinuing treatment; if patients have the right to die and the right to refuse treatment; if patients should be assisted to die or helped to undergo active euthanasia; and if severely disabled newborn babies should be allowed to die. The student nurses demonstrated considerable insight into contemporary nursing issues and were ready to act as

patient advocates. Professional responsibility demands that good nurses advocate strongly for patients' choices.
PMID: 14529113 [PubMed - indexed for MEDLINE]

Pharos Alpha Omega Alpha Honor Med Soc. 2003 Summer;66(3):24-6.

Journey through illness. A perspective on the patient-physician relationship.

Vaishnava P.

vaishnav@msu.edu

Publication Types:

Biography

Historical Article

Personal Name as Subject:

Dante

PMID: 14520790 [PubMed - indexed for MEDLINE]

Pharos Alpha Omega Alpha Honor Med Soc. 2003 Summer;66(3):12-5.

What I learned while dying.

Giller CA.

University of Texas Southwestern Medical Center, Dallas Southwestern Medical School, USA. cole.giller@utsouthwestern.edu

PMID: 14520786 [PubMed - indexed for MEDLINE]

Pharos Alpha Omega Alpha Honor Med Soc. 2003 Summer;66(3):4-7.

The evolution of palliative care.

Saunders C.

St. Christopher's Hospice. info@stchristophers.org.uk

PMID: 14520783 [PubMed - indexed for MEDLINE]

Profiles Healthc Mark. 2003 Sep-Oct;19(5):2-3.

Customer relationship marketing builds patient base.

Rees T.

Tom Rees discusses customer relationship marketing as it is being implemented by healthcare systems and hospitals.

Publication Types:

Editorial

PMID: 14503415 [PubMed - indexed for MEDLINE]

Qual Life Res. 2003 Sep;12(6):599-607.

Comment in:

Qual Life Res. 2003 Sep;12(6):609-10.

Whose quality of life? A commentary exploring discrepancies between health state evaluations of patients and the general public.

Ubel PA, Loewenstein G, Jepson C.

VA Health Services Research and Development Center of Excellence, VA Ann Arbor Healthcare System, Ann Arbor, MI, USA. paubel@umich.edu

There is often a discrepancy between quality of life estimates from patients and the general public. These discrepancies are of concern to the disability community, who worry that the public does not understand how valuable life can be for people with disabilities; policy planners, who must decide whose quality of life estimates to use in economic analysis; and practitioners and patients facing difficult medical decisions, who may have to worry that people have difficulty imagining unfamiliar health states. We outline several factors that may contribute to these discrepancies. Discrepancies might occur because patients and the public interpret health state descriptions differently--for example, making different assumptions about the recency of onset of the health state, or about the presence of comorbidities. Discrepancies might also arise if patients adapt to illness and the public does not predict this adaptation; because of response shift in how people use quality of life scales; because of a focusing illusion whereby people forget to consider obvious aspects of unfamiliar health states; because of contrast effects, whereby negative life events make people less bothered by less severe negative life events; and because of different vantage points, with patients viewing their illness in terms of the benefits that would result from regaining health, while the public views the illness in terms of the costs associated with losing good health. Decisions about whose values to measure for the purposes of economic analyses, and how to measure discrepancies, should take these potential contributing factors into account.

PMID: 14516169 [PubMed - indexed for MEDLINE]